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ABSTRACT

This document contains a summary of the 3-day Conference on Research Related to the Prevention of Mental Illness, Mental Retardation, and Substance Abuse. Part I, Introduction, discusses the need to stimulate collaboration between service providers and university-based researchers as the primary goal of the conference and lists specific objectives developed to achieve this goal. Participants at the conference are described and the nature of Community Service Boards is explained. The prepared text of King Davis' keynote address is presented in part II of the report, "Higher Education in the Public Health Systems: Approaches to Collaboration." In his address, Davis discusses the issues of interim strategies, prevention phases, historical overview, knowledge and public policy, parallels in medicine, state and federal responsibility, goals of state mental health, higher education, higher education and mental health relationships, impediments to collaboration, and collaboration around prevention. Part III looks at the needs and obstacles involved in promoting collaboration and part IV examines future directions for collaboration. The appendices contain a list of participants, conference evaluation results, and the conference agenda. References are included. (NB)

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# Research Related to the Prevention of Mental Illness, Mental Retardation and Substance Abuse: Stimulating Collaboration Between University-based Researchers and Service Providers

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A Publication of the Department of Mental Health and Mental Retardation In Cooperation with Virginia Commonwealth University

Conference Proceedings

December 1985



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# RESEARCH RELATED TO THE PREVENTION OF MENTAL ILLNESS, MENTAL RETARDATION AND SUBSTANCE ABUSE: STIMULATING COLLABORATION BETWEEN UNIVERSITY-BASED RESEARCHERS AND SERVICE PROVIDERS

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Conference Proceedings

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This publication was made possible by indepth discussions with many of the above people who gave their time freely, and the notes kept by the recorders of small group discussions. Although not specifically cited in the text, ideas and thoughts of the leaders and participants of the Conference are interwoven throughout the publication.

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# PART I

## INTRODUCTION

Research that seeks to provide knowledge for preventing mental health problems is a cornerstone for developing prevention strategies. However, the structure of the mental health field, including training, tends to separate clinicians from researchers and the process of research. As a result, many conceptual and pragmatic obstacles block the collaboration of service providers and researchers in doing prevention research. Price and associates (1980) view the disparity between researchers and practitioners as one of the most important gaps to be closed in the field of primary prevention. They recognize that "[a]lthough the ultimate success of their prevention efforts requires interdependence and collaboration, all too little or no dialogue exist between the two groups" (p.13).

The Virginia Department of Mental Health and Mental Retardation (Office of Prevention and the Office of Research) and Virginia Commonwealth University, sponsored a conference on Research Related to the Prevention of Mental Illness, Mental Retardation, and Substance Abuse on May 8 through 10, 1985. The primary task for the planners and participants of the Conference was to begin the process of dialogue, thus making collaborative efforts possible. The Conference was effective in creating a forum for the exchange of ideas and the development of relationships. This summary of the three-day Conference is intended to reflect the process of the group dynamics and to account for the essence of the major issues identified.

## STIMULATING COLLABORATION: THE PRIMARY GOAL

Stimulating collaboration between service providers and university-based researchers requires bringing the two groups together for discussion and for the development of working relationships and awareness of each other's problems. Concentration on the political and intellectual aspects of collaboration and attention to the interpersonal development of relationships were viewed by the planners of this conference as critical components in stimulating collaboration around research. Several objectives were specified to achieve this primary goal:

- Promoting the development of personal relationships through a program and environment conducive for the free exchange of ideas and interpersonal interaction;
- determining the obstacles and barriers that would make collaboration difficult, and beginning to gather ideas toward resolving them.
- Initiating a plan of action for researchers and service providers in the same geographic areas.
- Establishing a forum and operating system from which long-term commitment toward collaboration can grow;
- Increasing the awareness of current research and research needs related to prevention.

The impetus for the meeting stems from the overall commitment of the Virginia Department of Mental Health and Mental Retardation to encourage, stimulate, and utilize prevention research. In his opening comments to the Conference participants, Joseph Bevilacqua, Ph.D., Commissioner, clearly reaffirmed the support of the Department toward prevention research. During the past year, the Office of Prevention organized meetings in several universities to bring together local providers of service and researchers to discuss needs, resources, and opportunities. Three primary points were

established: (a) more prevention-related research was being conducted than service providers and researchers were aware of; (b) additional research framed with service providers' needs in mind might be attempted if resources and opportunities were widely shared; and (c) openness to and enthusiasm for further discussion was apparent.

## PARTICIPANTS

Given the focus on relationship development between service providers and researchers, the Conference was limited to fifty participants to enhance interaction opportunities. Twenty-five service providers from community service boards (CSBs) and their contract agencies and 25 university-based researchers were invited to the three-day symposium (the list of participants is included in appendix A). The service providers, representing a variety of programs and regions, were selected by the Office of Prevention and the Office of Research. The researchers were selected after visits to various universities revealed those involved in current or planned prevention projects. The universities represented were: College of William and Mary; Eastern Virginia Medical School; George Mason University; Hampton University; Old Dominion University; University of Virginia; Virginia Commonwealth University; and Virginia Polytechnic Institute and State University. Agencies and CSBs were represented from the following Virginia localities: Abington; Alexandria; Annandale; Chesapeake; Chesterfield; Danville; Fairfax; Goochland; Harrisonburg; Lexington; Lynchburg; Martinsville; Petersburg; Radford; Reston; Richmond; Roanoke; South Boston; Williamsburg and Winchester. One-page descriptions of each participant's prevention

activities were distributed at the beginning to enhance acquaintanceship and for later reference and facilitation of networking and collaborative efforts.[1]

Community Services Boards

While a large part of the service provider group were from CSBs and their contract agencies, little was understood by many of the researchers about the nature of these boards. A brochure description of CSBs from the Virginia Department of Mental Health and Mental Retardation (1984) is as follows:

> Community Services boards (CSBs) are the local governmental agencies, which are responsible for local mental health, mental retardation and substance abuse services. Boards function as service providers, client advocates, organizers, planners and advisors to their local governments and as the focal point for fiscal and programmatic accountability.
>
> CSBs are also composed of between five and 15 individuals who are appointed by city councils and boards of supervisors that established the boards. Currently, approximately 480 citizens serve on the 40 existing community service boards.
>
> The enabling legislation, Chapter 10 of Title 37.1 of the Code of Virginia, was enacted in 1968, and the first two boards were established then in Arlington and Prince Williams counties. Since that time, 38 additional boards have been

[1]Copies of the one-page descriptions may be obtained by request to the Office of Prevention, Virginia Department of Mental Health and Mental Retardation, PO Box 1797, Richmond, Virginia, 23214.

created, and now some services are available in every city and county in Virginia — 136 localities in all — and all but two jurisdictions have joined a board.

CSBs were established to provide services in the most accessible, therapeutic and least restrictive settings, using all available community resources and the clients' natural support systems (family, friends, work, etc.) to ameliorate handicapping conditions, stimulate growth and development and encourage realization of maximum potential.

The services are provided through a board and diverse network of boards and programs. Twelve CSBs serve single jurisdictions; 28 serve between two and 10 localities each. Four hundred and fifty separate programs are supported through CSBs, 265 directly and 185 contractually. The CSBs offer varying combinations of the five core services of the Department: emergency service; residential services; inpatient care; outpatient support services; and prevention/early intervention services.

**RELATIONSHIP BUILDING**

Long-term collaboration is enhanced when interpersonal dynamics between potential collaborators receive attention. Improving maintenance functions (social and emotional interaction of group members) has increased quality and quantity of productivity in task groups and is a widely accepted principle of group theory (Brill, 1976; Hackman & Morris, 1975; Steiner, 1972). Given the diversity in job expectations and the goal of promoting

collaborative work, maintenance functions became one of the priorities for the planners of the Conference.

The Conference was convened at the Moton Conference Center in Gloucester, Virginia, a well-equipped conference facility. The location chosen reflected the desire to provide an atmosphere conducive for relationship building between participants. The rural setting was ideal for "retreat" activities, such as walks along the York River, thought provoking conversations, and basketball games. Participants discovered personal connections with each other that set the stage for productive working relationships. This informal setting helped to reduce the barriers that can be present with such a diverse group.

Two additional strategies were employed to help participants build relationships needed for collaborative work. First, the schedule of the Conference was designed to create opportunities for formal and informal exchange. Unlike a typical conference agenda of several paper presentations, the Conference placed a high value on small group discussions and informal activities so as to encourage relationships and to provide a forum for exchanging ideas and working out issues. Second, breaking down into small groups by geographic locations was another approach to facilitate relationship building. Geographic closeness encourages collaboration throughout the year.

**KEYNOTE SPEAKER**

King Davis, Ph.D., Galt Scholar[2] and Professor of the School of Medicine and the School of Social Work, Virginia Commonwealth University

[2]The Galt Scholar position, established by the legislature of the Commonwealth of Virginia, was created to "strengthen professional ties between State hospitals and training centers for the mentally handicapped and Virginia's universities and medical schools ... [and] to develop cooperative relationships with the Department of Mental Health and Mental Retardation" (House Joint Resolution 112, 1982).

presented the key note address, as well as provided invaluable insight during the Conference. He has extensive experience and scholarly work in both the academic and mental health sectors. His experience in this capacity made him an excellent choice as the keynote speaker. His keynote address was thought provoking and provided the Conference with a foundation for further exploration. His prepared text of the keynote address is presented in the following section.

## PART II

## HIGHER EDUCATION IN THE PUBLIC HEALTH SYSTEMS: APPROACHES TO COLLABORATION

King Davis, PhD.

### INTRODUCTION

The words of Carl Sagan and the philosophical perspective of the Roman philosopher Seneca provide a starting place for research inquiry:

> Our feeblest contemplations of the cosmos stimulate us. There is a tingling in the spine, a catch in the voice, a faint sensation as if a distant memory of falling from a height. We know we are approaching the greatest of mysteries.
>
> The size and age of the cosmos are beyond ordinary human understanding. Lost somewhere between immensity and eternity is our tiny planetary home. In a cosmic perspective, most human concerns seem insignificant, even petty, and yet our species is young and curious and brave and shows much promise. In the last few millennia, we have made the most astonishing and unexpected explorations that are exhilarating to consider. They remind us that humans have evolved to wonder, that understanding is a joy and that knowledge is a prerequisite to survival and change. I believe our future depends on how well we know this cosmos, in which we float like a mote of dust in the morning sky.
>
> But the time will come when diligent research over long periods will bring to light things which now lie hidden. A single lifetime, even though devoted entirely to the topic, would not be enough for investigation of so vast a subject.
>
> And so this knowledge will be unfolded only through long successive ages. There will come a time when our descendants will be amazed that we did not know things that are so plain to them. That we did not actively pursue change... But — many discoveries are reserved for ages still to come, when memory of us will have been effaced from the earth. Our universe is a sorry little affair unless it has in it something for every age to investigate. Nature does not reveal its mysteries once and for all (Sagan, 1980).

The words of Carl Sagan and the philosophical perspective of Seneca are particularly apropos to our sojourn into the universe of prevention.

At the outset, it seems important for us to place our collective meeting here into perspective. While there are obvious precedents for collaborative meetings between representatives of the higher educational system and the mental health system, our meeting here is significant in that we are here to share our conceptualizations of approaches to preventing aspects of mental illness, mental retardation and substance abuse. These topics are as vast and complex, as ponderous, and as exciting as those that confront the astronomer and the philosopher. We are here to be a part of this nascent third revolution in the field of mental health. This is indeed the age of prevention.

## INTERIM STRATEGIES

Three major ideas of Sagan and Seneca strike me as of particular relevance to the problem of prevention research and the differing perspectives on the efficacy and probability of preventing mental disorders:

- Diligent research will bring to light things that now lie hidden.
- Knowledge will be unfolded only through long successive ages.
- Nature does not reveal its mysteries once and for all.

Two basic questions are stimulated by these ideas: (a) what role does prevention play in society?; and(b) what is it that societies do in the interim between discovery of a mental health problem and its resolution through prevention?

Anthropologically, the sine qua non of all living species is their capacity/success in surviving---a survival balanced by the ancient interplay of reproduction on the one hand, and on the other by the inveterate effort to prevent death, pain, loss, disability and dysfunction. At varying times, all societies are characterized by the presence of acute, as well as, chronic

debilitating and life threatening diseases, problems and social conditions. Immediately one thinks of the plague, the potato famine in Ireland, mass starvations in Africa, numerous deaths from smallpox, the spread of polio, tuberculosis and now A.I.D.S., as examples of macro disorders.

We have example after example of how societies respond to these disorders. These responses are worthy of our study and investigation. What distinguishes these responses? Why are they initiated and when? At what point in the cycle of disorder are they initiated? What combination of forces seem necessary before societal resources are combined to prevent disorder? What kind of disorders take precedence in the cycle of prevention? The disorders are not just themselves intriguing, but also the strategies that are developed and implemented between the onset of a problem and its eventual resolution. For example, why is it that the United States developed institutional care as a primary response to disorders, such as mental illness, mental retardation, crime, poverty, tuberculosis, aging and many others?

**PREVENTION PHASES**

What I am suggesting and proposing is that there are phases and stages of prevention, and not just different models. Furthermore, I propose that between the various phases that there are a variety of interim strategies that societies adopt and implement, which act as mechanisms for maintaining a semblance of order:

| | |
|---|---|
| Phase One: | Problem awareness and identification; |
| Phase Two: | Identification of probable causality (scientific, experimental, or speculation); |
| Phase Three: | Testing and experimentation of probable causes; |
| Phase Four: | Discovery of the factors that ameliorate the causes; |
| Phase Five: | Implementation of preventive intervention. |

Between each of these phases I suggest that a society adopts and implements a variety of interim or interphase strategies for managing disorders, responding to them, and in some respects delimiting their effects. Obviously some societies adopt an interim strategy and utilize it consistently, regardless of its proven effects on the initial problem. Over the milennia, numerous interim or interphasic strategies have been utilized to respond to problems:

- Prayer
- Migration
- War
- Irrigation
- Avoidance
- Slavery.

In the mental health field we have historically utilized similar phases, while our strategies have been different. These strategies include:

- Family care
- Religiously-based care
- Punishment, injury, burning, death
- Institutionalization
- Psychodynamically-based treatment
- Deinstitutionalization
- Community mental health
- Self help and community support
- Rehabilitation

Because of the absence of success in finding causes, the mental health field remains mired in the problem awareness and identification phase (Phase I),

and more importantly continues to debate about the effectiveness of various vertical interim strategies. The horizontal progress has been gradual. In my estimation, the most efficacious interim strategy is rehabilitation.

## HISTORICAL OVERVIEW

If one looked microscopically over the 222 year landscape of the ubiquitous problem of mental disorders and the society's incremental policy and strategy responses (starting with the establishment of Eastern State Hospital in 1763 to the recent results of studies of chromosonal markers in Down's Syndrome at the Medical College of Virginia), two impressions would stand in stark relief:

- The problem of mental disorders (mental illness, mental retardation and substance abuse) cannot be ameliorated by providing interim strategies (treatment, hospitalization, community-based care, psychotherapy or narcoleptics) to individuals after they become seriously impaired.
- Mental health research, while promising, has historically and currently been unable to identify the specific etiology of most of the major mental disorders.

The history and course of mental disorders in the world suggest that while the zeitgeist remains focused on treatment strategies, the future of the field appears to inhere in the complex labyrinth of rehabilitation and prevention. In spite of the fact that our current understanding of psychology, neuroscience, biochemistry, and genetics are as yet insufficient to formulate a precise strategy of primary prevention, we have at this juncture reason for optimism and hope — better than at any other time in our past.

In 1760, newspaper accounts in the state of Virginia bemoaned the fact that a mentally-ill man, unemployed, disheveled and separated from his family, had brutally killed a defenseless neighbor in a senseless act of

violence. The concluding paragraphs of an accompanying editorial proposed that had Virginia places, policies, processes, and procedures for management of lunatics, then such heinous crimes would decrease rapidly in frequency, if not entirely, within a relatively brief period of time. Virginia lawmakers soon began the arduous polemical task of debating the need and creating policies and programs for the mentally disabled in the colonies. These discussions were not without an appeal to theory, propositions, speculation, and spurious relationships. Not only were lawmakers involved in deliberating policy, but so were scientists (from this country and Europe), moralists, clergy, physicians, scribes and the lay public. Each held varying, but conceptually limited, views of the etiology of mental disorders. It was these conceptualizations that in the final analysis influenced the emergence of the first mental health policies and strategies in America. As is well known, the house of Burgesses and a governor of Virginia promulgated the strategy of institutionalizing the mentally disabled in hospitals or asylums, modeled after those in Europe (Kety, 1980). The question for scholars is why was it that in the Jacksonian era the United States established omnibus institutions for housing all categories of individuals considered deviant? Rothman (1971) suggests that the tradition of institutionalization was the strategy for problems of mental disorders that stimulated fear and confusion within the colonial populace.

Two rather subtle issues can be drawn from the history of mental health policy in this country: (a) mental health policy and strategies are highly responsive to the concerns, idiosyncrasies and fears of the public; and (b) mental health policies and strategies are also responsive to the prevailing level of scientific knowledge, skills, and emphasis of the epoch. Where knowledge and the tools of science are limited, strategies are much more

likely to be based on public concern and fear. In such an environment primary prevention is not possible.

## KNOWLEDGE AND PUBLIC POLICY

In the absence of scientific knowledge and validation (and even in some instances when it is present), mental health policy makers have few options than to create policy on the basis of public pressure and fear or on their own theoretical conceptualizations of etiology. Often policy makers must choose strategies that promise efficacy, or at least will be expedient, in addressing the immediate situation.

Institutionalization, as the major treatment strategy for the severely mentally disabled, has remained the centerpiece of American mental health policy, even though data generated in the 1800's demonstrated that institutional care was not correlated to a cure or remission of mental disorders (Rothman, 1971). Although we may propose a third revolution in mental health care, with primary prevention as the cornerstone, the reality is that we are mired in a previous approach -- institutionalization. I would propose that the primary reasons for the perpetuity of the institution as the major strategy for responding to mental disorders are the absence of knowledge of the variables that precipitate the major mental disorders and the cultural remnants idiosyncratic to the Jacksonian era in America.

## PARALLELS IN MEDICINE

Parallels exist in general medicine to the relationship between prevention and treatment of mental disorders. Tuberculosis is a chronic communicable disease. During the 19th century TB killed over 35 million people (World Book Encyclopedia (WBE), 1982). Until 1882, patients with TB were confined to sanitoria, segregated from others under the belief that such environments would lead to the remission of symptoms. While there was some

evidence that bed rest and isolation were helpful, confinement to the sanitoria was ineffective as the major treatment strategy. It was not until 1882, when Koch identified the bacterial causation, that a method for controlling TB became possible (WBE, 1982). Prior to Koch's scientific discovery, public policy reflected prevailing theory, speculation, fear and ignorance. Once the etiology of TB was determined, several related events occurred: disease-specific treatments could be sought and eventually determined and the extraordinary mortality rate from the disease would be reduced from 200 per 100,000 in 1900 to less than 7.1 per 100,000 by 1958 (WBE, 1982). For our purposes, the sanitoria as the major strategy for the management of this chronic disease were no longer viewed as viable. Public attitudes toward the disorder changed as have public policies. Former TB sanitoria in Virginia are now utilized for the mentally disabled, such as Piedmont State Hospital and Cataba State Hospital.

**STATE AND FEDERAL RESPONSIBILITY**

Concomitant with the emergence of the institution and the emphasis on treatment was the concentration of responsibility for the mentally disabled on state governments. In the periods from 1763 to 1963 the major mental health policies governing services and programs for the mentally disabled in the United States were promulgated and financed primarily by state and local governments (Bloom, 1984).

Although the United States Congress passed the National Mental Health Act of 1946 (pl 79:538) state governments had previously created a labyrinth of laws, regulations and institutional strategies for 183 years that developed and maintained a burgeoning system of state hospitals for the

mentally disabled. The National Mental Health Act of 1946 was not binding legislation on state governments and did not directly mandate standards, policies or modification in the growth or characteristics of the state hospital system or the ideological basis of treatment that supported it. The federal entry into mental health policy was stimulated by an apparently precipitous decline in military readiness, and by the high incidence of psychiatric causalities following World War II (Bloom, 1984). To the credit of the U.S. Congress, the National Mental Health Act was designed to improve treatment services for the mentally disabled by providing federal monetary support for the creation of a single state mental health authority. The majority of federal funds for mental health was to be utilized for basic research. Regrettably, the office of prevention (a major part of basic research) was not funded until 1979 (Bloom, 1984).

The federal government has historically conceptualized the problem of caring for the mentally disabled as a state responsibility, thus obviating a substantive role, or a significant sharing of federal tax revenues until 1963. Had the federal government conceptualized the problem in terms of prevention and as a problem of national proportions, it is conceivable that funds would have stimulated each state to place a priority on prevention rather than treatment. It is also conceivable that the relationships between state mental health systems and research universities would be more enhanced.

## GOALS OF STATE MENTAL HEALTH

History confirms that the state is the primary agency that provides care for the majority of the mentally disabled, and therefore state-related universities should consider the characteristics of patients, manpower needs, fiscal resources, plans, and policies of state hospitals. A higher priority

needs to be given to the various problems, resources, and needs of the state mental health system within academia.

The state mental health system tends to provide services to individuals and groups at the lowest socio-economic level (Noble, 1985). State mental health patients tend to be at the greatest risk of chronicity and often time share the least developed support systems. These socio-economic characteristics make this category of patients less attractive to professionals and university professors alike, as subjects for either treatment or prevention research.

In the next decade the Virginia Department of Mental Health has the following goals:

- transition from an institutional-based system to a community-based system;
- national accreditation of all state facilities and improvement in the staff to patient ratio;
- emphasis on providing qualitative care to the most severely disabled.

The policy of the Department is to establish, maintain and support development of an effective system of treatment, training and care. In its mission statement, the Department of Mental Health reflects the historical emphasis on treatment as the zenith of the policies and strategies for the mentally disabled. However, prevention has been identified as a key element in identifying initiatives to achieve the Departmental goals. In my estimation, the short-term strategy most appropriate for the Department is to focus on community-based rehabilitation, while the long run strategy needs to be prevention.

The policies, goals and characteristics of the state mental health systems confirm that it is indeed a system in transition. There have been

major reductions in its funding base, compared to previous years. At the same time there is a continuing demand for services to support the transition to community-based care. In relation to its changes, the Department poses a number of questions:

- What mixture of factors is required to prevent and reduce the incidence of chronic disorder in young patients?;
- What combination of strategies and approaches will reduce or prevent disruption for families having mentally-disabled members?;
- What are the factors that maintain societal acceptance of institutional care as the basis of mental health treatment? What policies, actions or approaches are necessary to prevent the process of re-institutionalization of the mentally-disabled?;
- As scientific information regarding mental disabilities increases, what are the socio-cultural impediments to the utilization of such data in programs of prevention?;
- If data confirm that problems, such as alcoholism, have genetic linkages, what preventive role should be played by state mental health systems? Similar questions can be raised about schizophrenia and affective disorders;
- If research, aimed at identifying genetic markers for major mental disorders, should be able to identify persons at risk, how should such information be utilized?;
- What is the interim role of the state mental health system, during the period in which primary prevention ideas are sought and tested?;
- Since current state fiscal resources are invested in hospital-based treatment services, what role can state universities play in the exploration of the factors that would support prevention of mental disability in the Commonwealth?

**HIGHER EDUCATION**

During the same period in which state mental health systems have undergone major change, public and private universities too have experienced extensive changes, and from similar fiscal and legislative directions. Universities throughout the United States have experienced a serious erosion

of public confidence about the quality of their curricula, the effectiveness of their efforts, the integrity of their faculty and increasingly the corruption of its athletes (Chronicle of Higher Education, 1984). Several recent reports have outlined an incipient decline in public education at the graduate and undergraduate levels.

Over the past ten years there has also been an erosion in public financial support of higher education. Within the past four years, universities and colleges have experienced an almost total reversal of federal funds for education. Federal funding declines have increased significantly under the Reagan administration. There have also been significant changes in the policy atmosphere at the federal level toward higher education and toward the mentally disabled.

As a result of major funding declines, university presidents are now spending additional efforts to raise money from state governments and private foundations (Chronicle of Higher Education, 1984). Despite the increased effort by state governors to obtain federal funds for education, in 1982 state governments provided 30.3% of the operating budgets of universities and colleges, whereas the federal government provided only 11.5% (Chronicle of Higher Education, 1984).

As federal funds have declined overall for education, greater reductions are evident for professional education in health and mental health. Whereas NIMH and NIH once provided major financial support for graduate professional education, such funds are now largely non-existent (McPheeters, 1983). University programs are being forced to change substantially the kind and extent of programs they offer because of the decline of funding of basic education. The short term future is not promising.

## HIGHER EDUCATION AND MENTAL HEALTH RELATIONSHIPS

In some states, university teaching hospitals are being sold to private companies, residency training programs are being cut back, residents are being asked to finance more of their education, and allied health professional programs are being dismantled and closed out entirely (McPheeters, 1985a). As funds to support university educational programs and research have dwindled, the relationship between university and public mental health agencies have become more strained, according to the Southern Regional Education Board (McPheeters, 1985b).

McPheeters (1985b) proposes that relationships between universities and state mental health authorities and facilities have been strained and stressed for over 30 years. Part of the reason for this stems from the perceived differences in goals — direct service delivery within the public mental health agencies, and education and research within universities. He also proposes that many universities did not feel the need for collaborative relationships with public mental health systems, except as occasional training sites, because university funds were plentiful and came from the federal government. Universities were often unresponsive to the needs of the state mental health patients or the system overall. Universities and colleges could distance themselves from the problems of chronic disorder, and concentrate on the priorities of the federal bureaucracy or the interests of their faculty. Where these interests and priorities coincided with the needs of the state mental health system tended to be a product of fate rather than design. However, there are a number of obvious areas and needs for collaborative relationships between state mental health systems and universities and colleges.

As one compares and contrasts the characteristics, problems and parameters of the public mental health system and the higher education system, a number of areas in which collaboration already exists and areas in which collaborative activity is needed become apparent. Given the mission of the Department of Mental Health in Virginia and its legal responsibility to care for the mentally disabled, the most apparent area for collaboration is in the care and management of patients. Universities can help to identify what strategies and approaches are most efficacious for the categories of patients under the aegis of the state. What constitutes improvement for patients in the state system? What kind of scales need to be developed to measure improvement? Other areas in which some collaboration has taken place are in training and staff development, program design and evaluation.

Less work has taken place in mental health policy development and analysis. What is a policy of prevention, given the state of knowledge and skill? In addition, little work has taken place in administration and planning, and little work has taken place in the application of business technology in state mental health systems. Although the majority of collaboration has taken place in training, virtually no programs in higher educational systems focus on training individuals for work with chronic populations — the predominant populations serviced by the state system — or consistently grapple with the problem of prevention.

Since collaborative relationships are best built on reciprocity, we need to identify areas within the university and the state system that can be enhanced through better relationships:

- Given the precarious fiscal situation of universities with professional educational programs, there indeed may be specific financial incentives for concentrating parts of programs on target populations that are priorities for the state mental health system and key members of the general assembly;

- State facilities represent the most exciting potential for students, if the focus of their work in these programs is related to active research in preventive strategies, coupled with faculty involvement and interest;

- Curriculum development and design are challenged by the kinds of problems presented by the state mental health system;

- The possibilities for research are endless. The Virginia mental health system is the oldest in America. It has the largest MR facility in the United States, the oldest continuous state hospital in America, the first mental health facility in America for Blacks, a major forensic facility, and two facilities specifically for mentally-ill children. The data possibilities are indeed startling;

- The State Department of Mental Health also is the largest employer in the Commonwealth of Virginia. There are jobs for students, which is often times the mark of whether an educational program is successful among graduates;

- There are also joint appointment possibilities for faculty who are interested in research and practice within the context of mental retardation, mental illness, substance abuse and the criminally insane. No private system offers this extensive an array.

## IMPEDIMENTS TO COLLABORATION

While there are obvious areas of university state mental health affiliation, why isn't there more? Is the situation as dismal longitudinally as described by McPheeters (1983) -- a situation in which the fiscal ideosyncrasies of each system stifle efforts at creative collaboration, or is the relationship more similar to that described by Shern and Glover's (1984) report of Colorado's collaboration efforts? This report demonstrates that successful collaboration revolves around research.

Talbott (1984) describes a number of collaborative relationships in medicine and psychiatry in which relationships revolve around manpower and training. In Oregon for example, he indicated that psychiatry residents spend a portion of each of their four years of training in state hospitals, community mental health centers, and community support programs. At

Massachusetts General, content on chronic patients seen in public mental health systems is included in the curriculum. St. Vincent's Hospital in New York provides residents with information about chronic patients by participation on a prevention team designed for rehabilitation of the chronically disabled.

In Virginia and in other states a number of identified factors, operating independently in some instances and collectively in others, have tended to lessen our collaboration. Some of these factors are listed below.

Communication: In all too many instances the lines of communication between public mental health programs and the higher educational system simply do not exist. Staff and faculty who do not know each other can't communicate. There has not been any consistent system or process whereby communication linkages are established and nourished. Joint appointments and shared participation on curriculum committees, and agency planning staffs could help with this process. Joint staff meetings on occasion, joint training programs, case conferences, and consultation are all mechanisms that would facilitate much needed communication.

Historical Direction: Need for collaboration is affected by the historical directions the two systems have taken, and the priorities they have set. In the agencies, universities are seen as being distant and arrogant, while in the universities, public programs are often seen as resistive to change and isolated.

Mission: Traditionally universities perceive their missions as that of education and research, while public mental health systems have service and treatment as their major mission. Because of these different mission paths, some propose that the systems cannot collaborate.

Products: Universities produce graduates and knowledge, while the state mental health system generates released patients and service programs. The

products of the mental health system carried negative stigma and low prestige, while the products of the university carried prestige. Thus the feedback for the two systems tended to foster distal as opposed to closer relationships.

Given the stigmata associated with chronic mental disability and their perceived unattractiveness, university programs have often shied away from investment with these patients, viewing them as hopeless. Public mental health systems, their products, staff, and methods were not seen as offering universities an opportunity to advance their standing in their fields, professions and associations. For university faculty there was the belief that affiliation with a state facility would be indicative of inferiority and would not be useful for advancement within the university system. Regrettably, in many university systems affiliation with the state hospital did not carry any impetus towards advancement.

Structure: In many states there is simply no mechanism, impetus or process for facilitating or maintaining collaborative relationships between the higher educational system and the state mental health system.

Reciprocity: According to Shern and Glover (1984), a point of major conflict that negatively influences university and public agency relationships is the presence of undimensional rather than reciprocal exchanges. Universities have often entered relationships with state mental health agencies with the assumption that the agencies and their staff have virtually nothing to offer the university, other than facilities for students and data for studies. In order for collaborative relationships to develop and survive there must be planned reciprocity based on mutual respect and understanding.

Frameworks: There are indeed a plethora of perspectives that can be taken on any issue, problem, disorder or topic. Historically there may have been

extensive differences in the theoretical perspectives held in higher education and those held in state mental health systems. There are certainly differences of opinion relative to prevention, and its feasibility and desirability. Such differences are healthy and expected characteristics of scientific interaction. However where theory is held dogmatically the opportunity for collaboration is minimized.

Geographical Isolation: Some universities and state facilities are located some considerable distance from each other, inhibiting the development and maintenance of working relationships.

## COLLABORATION AROUND PREVENTION

In a conference sponsored by NIMH in 1980, it was noted by Emory and Goldston (1978) that if we seek to collaborate while assuming a very narrow conceptualization of prevention or of mental disorders we will fail inevitably. If we conceptualize the focus of preventive efforts as eliminating the problem of schizophrenia we are likely to be frustrated with the pace of progress. So how do we proceed? I propose that we proceed by first identifying what we know about the disorders that confront us. Secondly, a center, supported by the state, is needed for collecting, ordering, and disseminating information about prevention. This center would function adequately with a small staff and computer services designed for collecting information and insuring linkages. To some extent Virginia's Department of Mental Health/Mental Retardation, Office of Prevention is moving towards being that resource. Third, we need to identify a cadre of professionals from the universities and the mental health system who can help make changes in curriculum and practica.

Working together involves identifying the feasible research questions related to the prevention of major mental disorders that

we can pursue, given our resources. Concomitantly, we must identify the variety of resources that are needed to make this effort successful. I believe there is support potentially within the General Assembly and certainly within the Department of Mental Health/Mental Retardation for this effort.

## CONCLUSION

What is clear to me from a reading of history and the current scene in this country is that the American public continues to be mystified by the problem of mental disorder and fearful of the mentally disabled. Decisions within the local courts in Virginia that deny the development of community residential placements are indicative of this. However, this same history explains to us why this is so. The history is replete with example after example of actions taken by citizens to protect themselves from those whose illness are believed to have a high probability of violence, unpredictableness, and chaos. Invariably the response of the American public has been based on a linear logic system — identify the problem, agree on a solution, implement it, and see if it appears to work. Such linearity in relationship to disorders and problems of a wide variety has appeared to work. Several examples illustrate this point in American history: a problem with westward expansion was met by Americans who built roads and solved the problem; the problem with illiteracy was met by Americans who built schools; a problem with scientific competition was met by Americans who infused education with scientific emphasis; a problem with rampant crime was met by Americans who built prisons. Likewise, the poor, TB patients, orphans, and the mentally disabled were housed in poorhouses, sanitoria, orphanages, and asylums, respectively.

In many instances the American propensity for linear strategies has worked sufficiently well to reinforce the utility of linearity. As solutions appeared to work, anxiety associated with certain populations of undesirables subsided. In the process the linear approach to problems became concretized. Although it became known soon after their development that institutions were not the answer to major problems, they persisted. With tuberculosis, sanitoria remained until Koch's discoveries in 1882. Institutions for the mentally disabled began to be abandoned after 1955, when it was believed that the phenothiazines were the analogy to isoniazid. The difference was that disease specific treatment with TB was based on a clear identification of the tubercle bacilli and a series of specific tests. Yonkauer (1982) indicated that the problem of TB was resolved by "research of impeccable quality that helped identify the etiology", thus stimulating effective treatment. Once research was in place two situations emerged: TB could be prevented and the public's need for institutions disappeared.

The maladies that have confronted us for centuries, their side effects, their residue, their impact on the human spirit, the family and the society, call for us to redouble our efforts and shift our foci towards prevention. While we may not identify the neurological or genetic base of schizophrenia, we can hope and strive towards preventing such problems from becoming chronically disabling. We can hope that we can prevent such problems from destroying family homeostasis. We can realistically hope that we can prevent such problems and their attendant public misunderstanding from precipitating the reinstitutionalization of the mentally disabled.

I would like to end by sharing with you one of the axioms of Kwame Nkrumah (1969):

> If you expect for your work to change the course of history in your lifetime by 100%, you are a fool; if you believe that your work will change the course of history by even 50%, you are a hopeless egotist. The most that we can expect from our work during our life time is to change the course of history by less than one percent. But if we do so then we would be assured that such work will be so significant as to mark our names indelibly in the annals of history.

## PART III

## PROMOTING COLLABORATION: NEEDS AND OBSTACLES

Interaction between professionals of diverse job functions and perspectives promote stimulating thought and inspires the development of approaches that have potential for success. Diversity in this sense is a strength, but as in the case of many areas of strength there are concomitant limitations. Professionals with varying job functions have different needs and demands that potentially can be damaging to collaborative work. This section highlights the needs and potential obstacles that were identified and discussed in both the large and the small groups.

### RESEARCH PRIORITIES

Participants were divided into groups of service providers and researchers, and asked by the conference leaders to candidly discuss their research priorities and needs.

#### Service Providers' Priorities

The service providers were chosen to outline their needs first. The following are some of their major research priorities and interests:

- Prevention of substance abuse (particularly among youth);
- Prevention of school dysfunction;
- Prevention of adolescent pregnancy;
- Prevention of adolescent suicide;
- Prevention of child sexual abuse;
- Prevention of disability in young schizophrenics;

- Identification of risk factors and mediating variables for mental illness;
- Staff development;[3]
- Development of strategies to change the mental health system so that it is responsive to the above concerns.

Researchers' Priorities

The research group then proceeded to outline the following priorities:

- Establishment of criteria that will direct the process of collaborative research is more important than the actual phenomenon studied;
- Preparation of mental health providers and decision makers to be open to the findings of causal studies, regardless of the nature of such findings and the social and political controversy they may produce;
- Determination of topics for research in academia is an independent process that will vary with individual training, needs, and interests.

While the service providers' approach to research priorities was pragmatic and largely topic focused, the researchers' response concentrated on the collaboration process. Three factors may serve to explain the difference between the two perspectives: (a) service providers have need for applied research results in specific areas to direct their current intervention with clients; (b) topics for research of university faculty are usually individually determined (as indicated above) and therefore consensus on topic areas is not a central value; and (c) the university representatives were in a position of responding before they had an opportunity to develop their independent thinking on the question.

[3] Service providers indicated a strong desire for in-service training by university faculty in research and practice areas.

## CONSTRAINTS: BOTTOM-LINE ISSUES

The groups were asked to identify specific "bottom line" issues that require attention to make collaboration possible. The following issues were identified by the two groups.

### Service Providers' Issues

Protection of Clients: Service providers advocated that the research process should adequately protect clients' time, energy and confidentiality. Many clients struggling with difficulties and the symptoms that bring them to seek intervention are already burdened and perhaps at the edge of their coping capacities. A research project that asks clients to further extend themselves must account for how the additional expenditure of time and energy will affect their well-being. Client involvement is facilitated when direct ways are found to make research participation a reinforcing experience for them.

Direct Applicability: Service providers desired to participate in research that could be directly applied in the clinical setting. Research endeavors that were more esoteric than practical were considered not helpful in meeting immediate service delivery needs.

Joint Writing Opportunities: A clear desire was evident on the part of the service providers to share in the process of creating and implementing the research design and to share in the writing of the results. Service providers are aware of the need to increase their contribution to professional literature. Although time for professional writing for publication is not allotted in the schedules of most service providers, they understand the importance of such activity to improve the quality of service delivery.

Consistent Involvement: Service providers highlighted the concern that they wanted to participate in all phases of the research process in a mutual partnership with the researchers. Consistent and mutual involvement is difficult, particularly before and after the data gathering process is completed. The Colorado Division of Mental Health noticed a similar concern when they convened public mental health practitioners and university researchers to seek out the opportunities for research collaboration for the state of Colorado (Shern & Glover, 1984). As in Colorado's experience, the degree to which the collaboration will be genuine is a concern of service providers. They write: "In many instances, however, participation is limited to the status of a subject in the research with the agency having little or no input into the project design ... research which is conducted in this way is rarely of use to the agency and often times is quite disruptive to agency functioning (p.6)".

While client protection, joint writing, and mutual involvement in the research process are issues that both sides can endorse, the direct applicability of research to practice is an issue yet to be resolved. Questions about what type of research is useful reflects the core difference between the mission of service providers who meet the everyday demands of clients needing service, and academicians, who are to make contributions to new knowledge — which eventually influences strategy development for direct application.

The applicability of research was also a question for the Colorado Conference:

> Specifically, providers insisted that the research directly address the policy concern for which it was designed. Fairly or unfairly, much of the providers' experience with academically housed research indicated that the work often addresses abstract concepts in highly controlled and contrived situations. While this type of research may be valuable in

> increasing our basic understanding, it is often relatively worthless in applied settings, largely because of the artificiality of the research design (Shern & Glover, 1984, p.6).

Progress in defining usefulness of research would seem to occur when both sides agree on acceptable definitions and parameters of prevention research.

Researchers' Issues

Representatives from the universities identified several constraints, some of which were interrelated with the constraints identified by the service providers. The following were the "bottom-line" constraints of the research providers.

Research Quality: Attention to the quality of research was an imperative concern for the researchers. Slight errors in research design, methodological procedures, statistical analyses, and other areas of research can lead to major misinterpretation of results. Quality in research requires careful planning and diligent attention to details at all stages of the project.

Clear Expectations: Realizing that working relationships require mutual understanding of objectives, methods of achieving those objectives, and anticipated products, the researchers advocated that expectations be clearly defined prior to involvement in a collaborative effort. The formal or informal writing down of expectations and agreed upon approaches is one method of avoiding confusion as the project progresses.

Early Involvement: The university researchers highlighted the need to be involved at the beginning of research projects. In some instances, researchers from universities are asked to become involved in research efforts after the data have been collected or after methodological approaches have been decided. Such late involvement is difficult for the researcher and often undermines the quality of the research design.

Support: Two types of support were highlighted as useful from the researchers' perspective: resource support such as funding and manpower; and logistical and administrative support to overcome practical problems and administrative impediments. The researchers believed that this support by service agencies can make otherwise unattainable projects possible.

Long Term commitments: Researchers highlighted the value of long term commitments of service providers to a research plan. A research plan can often require several years, particularly when executing a longitudinal study.

Student Involvement: Involving students in collaborative research projects was identified by the researchers as valuable for student learning, and would help meet the manpower needs of implementing the research methodology (eg. student interviewers).

Publication: As criteria for publication acceptance become more difficult than before, researches need to assess the publication possibilities of a research project prior to their involvement. Some projects will have a low appeal to editorial boards of professional journals, regardless of the success achieved. Therefore, academicians must be concerned with some of the following questions: (a) will the research generate new knowledge?; (b) will the sample of subjects be large enough?; (c) how generalizable will the results be?; (d) is the topic a timely issue?; and (d) how many publications will the project generate when compared to the time and energy invested?

Mechanism for Sharing: Researchers identified a need for a structure that would facilitate the sharing of information and utilization of data between university systems and providing agencies.

Handling Controversial Findings: Sometimes research data suggest less than optimal findings, or worse, generate evidence opposite of the expected direction of the results. This may make certain intervention strategies suspect, and at times may put entire agency services in question. However, researchers would have to maintain a freedom to report findings, regardless of their nature, and to make recommendations for service improvements.

## SIMILARITIES AND DIFFERENCES

Both groups demonstrated a desire for quality in the provision of service, the collecting of data, and the use of findings for the purpose of improving service to clients. Researchers and service providers recognized the gaps that exist in mental health knowledge and are willing and prepared to work on solutions. They both face external pressures of either meeting the demands of increased caseloads or the pressure to publish.

While there were several areas of similarity, three areas of differences were prominent. First, the level of autonomy was far greater for researchers than the service providers to pursue research needs. Service providers must work through agency sanctions and policy set by agency executive directors and community service boards. Unlike providers, academic researchers have greater independency in choosing research topics and methods without regulation by boards.[4] Second, the groups also differ on the freedom to advocate policy change that research findings may suggest. Academicians have more freedom to present and advocate provocative changes than do the service providers because academicians are not usually held accountable to the

[4]Sometimes researchers need to gain approval from their university for data collecting techniques when using human subjects (particularly for direct experimental designs).

systems requiring the change. Finally, substantive differences existed between the two groups of participants on the primary focus of prevention research. For the most part, providers emphasized the evaluative aspect of applied research, particularly to evaluate the effectiveness of an intervention program or strategy. Although both groups understood the need for various types of research, attitudes and values differed on the significance of each. Academicians valued etiological, epidemiological, exploratory and other types of studies on both normal and pathological subjects that would inform theory development and increase knowledge for prevention strategies. Service providers valued research that had more immediate implications for intervention strategies as explained above. Reservations of academicians in doing applied research were also noted in the Colorado experience:

> While each of these concerns stemmed from the values which are endemic to the academic environment, the first issue [scientific quality of applied research] related to the relationship between scientific/scholarly values and stereotypes regarding applied research. Specifically, concern related to the scientific quality of applied research including questions regarding the research designs, the measurement approaches and the methodologies commonly employed. While the participants realized that these stereotypes had limited utility, they characterized applied research as quite time limited in conduct, often compromised in its design and conceptualization and, therefore, limited to its generalizability (Shern & Glover, 1984:p.6).

Values and attitudes involved in defining prevention further complicates negotiations on definitions. Despite the awareness of some participants of the definitional problem between, and sometimes within, the groups, the subject received little attention at the Conference.

**PLANS SET BY REGIONAL GROUPS**

After discussing needs and obstacles, each regional group established a plan for further work together after the Conference. Recent questionnaires,

completed by the participants, revealed much follow-up activity throughout the State. Examples of this activity include: (a) regional groups are meeting, formally and informally, to discuss prevention research; (b) other practitioners and university faculty are getting involved; (c) university faculty are providing consultations and workshops to service agencies; (d) student interns are being placed in service agencies; (e) contacts between faculties of different universities have been made to discuss research ideas and grant proposals and (f) service providers are investigating the possibility of adding research components to their prevention programs.

## PART IV

## FUTURE DIRECTIONS FOR COLLABORATION

The desirability and potential utility of prevention research collaboration have clearly surfaced in Virginia, as the participants of this conference have broken ground for constructing working relationships. The task that remains is to give shape and form to the ideas and concerns through follow-up action. Finding solutions to the constraints and concerns raised and securing commitments to particular projects are necessary steps to proceed.

This section gives several recommendations for future work in this area and provides a brief summary of the Conference.

### TOWARD COMMON DEFINITIONS

Attempts to provide one acceptable definition of two complicated concepts (prevention and research) for two diverse groups may prove to be an arduous and self-defeating task. Prevention will generate varying degrees of emphasis contingent on the nature of the participants' job functions. Researchers are generally interested in doing epidemiological and etiological study, while service providers desire more information at the direct intervention level.

Given a favored (and sometimes a forced) emphasis on a particular level of prevention requires flexibility in defining the type of research inquiry

needed. Heller and associates (1980) noted that during this pioneer time of prevention research both basic research and program evaluation are important. They state:

> At one extreme, basic research generating new knowledge of the etiology and epidemiology of various psychological disorders is needed. However, the results may have only remote implications for decisions about actual prevention program implementation. At the other extreme, evaluation of whether a particular program has met its goals may play an important role in the decision to continue that program in the future; but may contribute little to our understanding of the disorder or the processes by which it was prevented from occurring, without further research to test the generality of program effects or to pinpoint the most crucial program ingredients (p. 286).

An array of definitions is possible as the type of inquiry determines the research approach. Ideally, researchers and service providers should seek to understand the importance of various research designs and strive to contribute to prevention knowledge by undertaking projects at various prevention levels. Where possible, various research strategies can be incorporated in the same multi-year research plan that would meet the research needs of both service providers and researchers. Clearly, continued thought and discussion on defining prevention research is warranted.

## EXPLORING EXISTING KNOWLEDGE

While a few states have experimented with combining the research skills of the higher education systems with mental health agencies, this Conference has taken a lead in doing so with a clear emphasis on research related to prevention. A review of the literature and research related to prevention and collaboration would enhance the potential of future participants to further build upon existing knowledge and integrate past experiences. It is recommended that a review of this literature be made and reported to participants prior to the next conference.

Another productive step in preparing for the next conference is to connect with other states and groups who are attempting to bring together practitioners and researchers (such as, Colorado's Division of Mental Health). This sharing and exchange of ideas may generate new thought and inquiry.

## CREATING A RESEARCH AGENDA

The primary goal of stimulating collaborative research was clearly met throughout the conference. New objectives must now be added, one of which is to focus on the actual development of a research agenda. As a result of the Conference, research planning is proceeding at regional levels, which may be integrated as a major part of the next conference. Examples of planned projects could be presented by one or more of the geographic areas and success, constraints and other issues that arose from the collaboration could be explored.

These presentations become working samplers for learning and setting up future collaborative research projects. The planned procedures of methodology could be evaluated for potential of producing quality information that would be a benefit to all concerned. The issue of "mutual reciprocity" of the research and the effect it might have on prevention are just two of an array of topics that such presentations could stimulate.

Time for the generation of new ideas and plans for actual research projects could be structured in the agenda of the next conference. Specific topics could be evaluated and preliminary research plans developed. While geographic breakdowns are desirable to facilitate follow-through, these work sessions need not be restricted to geographic areas. Some participants believed that work outside of one's immediate geographic area would not be as

hindering as initially anticipated. Therefore, participants at future meetings may also value the opportunity to participate in research projects by topic areas. An early screening of priority in topics would be helpful in planning for topical work sessions. However, the actual number of research projects that are implemented are likely to increase when geographical proximity can be matched with topical interests.

**IMPLEMENTING A SYSTEM FOR EXCHANGE**

Participants expressed a desire to create a system that would facilitate exchange of ideas and to disseminate information. Service providers were especially surprised to learn of some of the exciting research projects occurring within miles of their agencies. It was agreed that the Office of Prevention would be an appropriate center for creating a communication system for prevention research.

Several steps have been initiated through the Office of Prevention to improve the communication linkages and to promote prevention research during the last few months. First, coordination and assistance has been provided to the regional groups. Second, a planning committee has been established to help guide the Department's future direction of prevention research with the mental health system. N. Dickon Reppucci, Ph.D., Professor, University of Virginia, will serve as scientific chair of the committee. Third, the Department created a nine-month position for a part-time prevention research planner to be responsible for knowing the current mental health, mental retardation, and substance abuse prevention research activities in Virginia and for promoting research in the area of prevention. Susan Gelleris was appointed to this position. Finally, Marcia Penn, Director of the Office of Prevention, and Martin Bloom, Professor, School of Social Work, Virginia Commonwealth University, are currently evaluating the structure and function

of the Office of Prevention for the purpose of improving its prevention capabilities.

**IN SUMMARY**

Prevention research is becoming rather difficult with research dollars shrinking and mental health cutbacks in the face of increasing demands for research productivity for university faculty and growing client caseloads for mental health providers. Researchers and service providers in the mental health field are asked to do more with less resources. Barriers can solidify as a response when professionals and systems protect their limited resources, most precious of which is their time. Careful attention to the needs of both groups was evident, as participants searched for mutual reciprocity that would ultimately lead to collaborative efforts.

Collaboration between universities and mental health systems is at an infancy stage, just now being considered by other states. This Conference combines not only the need to enact research collaboratively, but also to focus on prevention aspects of mental health, mental retardation, and substance abuse. The participants of the Conference have set into motion a beginning effort of collaboration in Virginia, while establishing a model for others interested in collaboration. Moving away from traditional academic models, the Conference focused on the process of developing the relationships necessary for ongoing work and as a result has stimulated collaboration between university faculty and service providers.

## REFERENCES


Bloom, B.L. Community mental health. Monterey: Brooks/Cole Publishing Co., 1984.

Brill, N. Team-work: Working together in the human services. Philadelphia: J.B. Lippincott Co., 1976.

Chronical of Higher Education, Fall, 1984.

Emory and Goldston, S.E. Community support program of NIMH. Rockville: NIMH, 1978.

Hackman, J. and Morris, C. Group tasks, group interaction process and group performance effectiveness: A review and proposed integration. In L. Berkowitz (Ed.). Advances in experimental and social psychology. Vol. 8. New York: Academic Press, Inc., 1975.

Heller,K; Price, R.H.; and Sher, K.J. Research and evaluation in primary prevention: Issues and guidelines. In R.H. Price; R.F. Ketterer; B.C. Bader; and J. Monahan (Eds.). Prevention in mental health: Research, policy, and practice. Vol. 1. Beverly Hills: Sage Publications, 1980.

House Joint Resolution 112, Commonwealth of Virginia, 1982.

Kety, S. The syndrome of schizophrenia: Unresolved questions and opportunities for research. British Journal of Psychiatry. Vol. 126: 421-426, 1980.

Noble,J. Deinstitutionalization. Unpublished paper, 1985.

Price, R.H.; Bader, B.C.; and Ketterer, R.F. Prevention in community mental health. In R.H. Price; R.F. Ketterer; B.C. Bader; and J. Monahan (Eds.). Prevention in mental health: Research, policy, and practice. Vol. 1. Beverly Hills: Sage Publications, 1980.

McPheeters, H.L. Trends and issues in health care delivery and health manpower. Paper presented for the meeting of Health and Human Services Southern Regional Education Board. Atlanta: January, 1985a.

McPheeters, H.L. Personal letter, 1985b.

McPheeters, H.L Relationships between universities and agencies to better meet public needs. Paper presented for the meeting of the Commission of Mental Health and Human Services. Williamsburg: July, 1983.

Nkrumah, K. Axioms. New York: International Publishers, 1969.

Rothman, D. Discovery of the asylum. New York: Little, Brown and Co., 1971.

Sagan,C. Comos. New York: Random House, 1980.

Shern, D.L. and Gover, R.W. Higher education and the public mental health system: Opportunities for collaboration in applied research. Denver: Colorado Division of Mental Health, 1984.

Steiner, I. Group process and productivity. New York: Grove Press, Inc., 1972.

Talbott, J.A. Education and training for the treatment and care of the chronic mentally ill. Unpublished paper adapted from J.A. Talbott. The chronic mentally ill: Five years later. New York: Grune and Stratton, 1984.

Virginia Department of Mental Health and Mental Retardation. Caring for people is our business. Brochure, 1984.

World Book Encyclopedia. Vol. 19. Chicago: World Book Publishing Co., 1982.

Yonkauer, A. To control the world's cancer. American Journal of Public Health Vol. 72, no. 7: 650, 1982.

## APPENDIX A

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## APPENDIX B

Conference Evaluation Results (n=30)[5]

PART I

Participants rated and commented on their perceptions of the degree to which the Conference met some of the major objectives. A three-point rating scale was used:

| 1 | 2 | 3 |
|---|---|---|
| not achieved | moderately achieved | fully achieved |

A. The Conference demonstrated the committment by the Department of Mental Health and Mental Retardation to the promotion of prevention research.

Average Rating: 2.7

B. The Conference established "connections" between community service providers and university-based researchers.

Average Rating: 2.4

C. The Conference provided a forum for information and data exchange re: current prevention activities and research needs.

Average Rating: 2.3

D. The Conference identified resources by geographic location for intra-regional cooperation.

Average Rating: 2.2

E. The Conference developed mechaism for continuing contact and collaboration.

Average Rating: 2.5

[5] Participants supplied written comments throughout the evaluation. These comments were greatly appreciated and provided insight for future conferences.

Part II.

Participants were asked to rate the following specific activities and facilities in terms of their positive or negative impact on the achievement of the general goals of the Conference.

| | Positive | Negative | No Response |
|---|---|---|---|
| A. General format/structure of Conference | 30 | 0 | 0 |
| B. Address by Galt Scholar | 30 | 0 | 0 |
| C. Small group sessions: May 8, 1985 | 25 | 1 | 4 |
| May 9, 1985 | 26 | 1 | 3 |
| May 10, 1985 | 15 | 7 | 8 |
| D. Roundtable: "Prioritization" | 23 | 5 | 2 |
| E. Large group sessions | 28 | 1 | 1 |
| F. Geographic and functional distribution of Conference participants | 25 | 2 | 3 |
| G. Informational packets and materials | 28 | 0 | 2 |
| H. Recreational Programs | 28 | 0 | 2 |
| I. Accommodations/meals/facility resources | 25 | 4 | 1 |

Part III

Participants were asked if they would be interested in attending a similar meeting in the future. Twenty-eight responded yes and two responded no.

APPENDIX C

# VIRGINIA SYMPOSIUM ON RESEARCH RELATED TO THE PREVENTION OF MENTAL ILLNESS MENTAL RETARDATION, AND SUBSTANCE ABUSE

Moton Conference Center
Gloucester, Virginia
May 8-10, 1985

**May 8, 1985**

*Education Building*

| | |
|---|---|
| 3:30pm | REGISTRATION (COFFEE) |
| 4:00pm | OPENING REMARKS/INTRODUCTIONS<br>John P. Hill |
| 4:20pm | WELCOME/INTRODUCTION OF GALT SCHOLAR<br>Howard Sparks |
| 4:40pm | "HIGHER EDUCATION IN THE PUBLIC MENTAL HEALTH SYSTEMS: APPROACHES TO COLLABORATION"<br>King Davis |

*Main House/Grounds*

5:20pm - 6:20pm — SMALL GROUP DISCUSSIONS

Issue: Promoting Collaboration Between MH/MR/SA Service Providers and University Based Researchers

Group 1
Joseph Galano, Facilitator
Anthony Vitiello, Reporter

Group 2
John Morgan, Facilitator
Thomas Ollendick, Reporter

Group 3
Bob Cohen, Facilitator
George Pratt, Reporter

Group 4
Elizabeth Morrissey, Facilitator
Michael Gilmore, Reporter

DINNER
(6:30pm - 8:00pm)

*Education Building*

| | |
|---|---|
| *8:00pm - 9:00pm* | *GENERAL SESSION*<br>*Robert Ware*<br><br>*Opening Remarks*<br>*Joseph J. Bevilacqua*<br><br>*Reports From Small Groups and Discussion Participants* |
| *Recreation Room* | |
| *9:00pm* | *SNACKS, BEVERAGES, RECREATION* |

***May 9, 1985***

| | |
|---|---|
| | *BREAKFAST*<br>*(7:30am - 8:45am)* |
| *Education Building* | |
| *8:45am* | *OBSERVATIONS AND REFLECTIONS*<br>*King Davis* |
| *9:15am* | *ROUNDTABLE*<br><br>*Issue: Identification and Prioritization of Prevention Research Needs in the Public Sector*<br>*Facilitators:*<br>*Marcia Penn*<br>*Robert Ware*<br>*John Hill* |
| | *COFFEE*<br>*(10:30am - 10:45am)* |
| *10:45am* | *ROUNDTABLE (cont'd)* |
| | *LUNCH*<br>*(12:00pm - 1:15pm)* |
| *Grounds* | |
| *1:15pm - 2:00pm* | *INFORMAL GROUPS MEET AROUND TOPICS OF MUTUAL INTEREST* |

*Main House/Grounds*

*2:15pm - 4:15pm* — *SMALL GROUP DISCUSSIONS BY GEOGRAPHIC AREAS*

*Issue: Improving Intraregional Cooperation Between Service Providers and University Based Researchers*
*(Facilitators and Reporters to be determined by groups)*

*Education Building*

*4:30pm - 6:00pm* — *GENERAL SESSION*
*Reports from Small Groups and Discussion*

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*DINNER*
*(6:30pm - 8:00pm)*

*Recreation Room*

*8:00pm* — *ENTERTAINMENT, RECREATION*

**May 10, 1985**

*BREAKFAST*
*(7:30am - 8:45am)*

*Education Building*

*8:45am - 9:15am* — *OBSERVATIONS AND REFLECTIONS*
*King Davis*

*Main House/Grounds*

*9:30am* — *SMALL GROUP DISCUSSIONS*

*Issue: Developing Action Plans for Prevention Research Collaboration and Follow-up*
*(Facilitators and Reporters to be determined by groups)*

*COFFEE*
*(10:30am - 10:45am)*

*10:45am* — *SMALL GROUPS (cont'd)*

*LUNCH*
*(12:00pm - 1:00pm)*

*Education Building*

| | |
|---|---|
| *1:00pm* | *GENERAL SESSION*<br>*John P. Hill* |
| | *Reports from Small Groups and Discussion Participants* |
| | *SUMMARY*<br>*Robert Ware* |
| | *FUTURE PERSPECTIVE*<br>*King Davis* |
| | *CLOSING REMARKS*<br>*Marcia Penn* |
| *2:30pm* | *ADJOURNMENT* |

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